PRINTED: 05/13/2011 FORM APPROVED

CENTERS FO	R MEDICARE & MEDI	CAID SERVICES			o	MB NO. 0938-0391
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155231		IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED	
		155231	B. WING		04/25	/2011
NAME OF	DDOWNED OF CURDING		STREET	ADDRESS, CITY, STATE, ZIP COD	E	
NAME OF	PROVIDER OR SUPPLIE	EK .	701 S (DAK STREET		
RANDO	LPH NURSING HC	DME	WINCH	IESTER, IN47394		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	CTION	(X5)
PREFIX	(EACH DEFICIE	ENCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	JLD BE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
K0000						
	A I : C · C · C · C	V. 1. D	120000			
	1	Code Recertification and	K0000			
		Survey was conducted by				
		te Department of Health in				
	accordance with	h 42 CFR 483.70(a).				
	Survey Date: 0	04/25/11				
	Facility Numbe	er: 000136				
	Provider Number: 155231					
	AIM Number: 100275450					
	Surveyor: Mar	k Bugni, Life Safety Code				
	Specialist					
	F					
	At this Life Saf	ety Code survey, Randolph				
		was found not in				
	1	h Requirements for				
	1	Medicare/Medicaid, 42				
	CFR Subpart 48	83.70(a), Life Safety from				
	1	00 edition of the National				
		Association (NFPA) 101,				
	1	de (LSC), Chapter 19,				
	1	Care Occupancies and				
	410 IAC 16.2.					
	This one story f	facility was determined to				
	1	11) construction and fully				
	1 ' '	ne facility has a fire alarm				
	_	oke detection in the				
	1 *	paces open to the corridors.				
	_	a capacity of 88 and had a				
	1	the time of this visit.				
	i census of /4 at	me mile of mis visit.	1	Ī		1

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EPSJ21

Facility ID:

000136

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155231	(X2) MU A. BUII B. WING	DING	NSTRUCTION 01	(X3) DATE S COMPL 04/25/2 (ETED
NAME OF PROVIDER OR SUPPLIER RANDOLPH NURSING HOME			P. W.I.	STREET AI 701 S O	DDRESS, CITY, STATE, ZIP CODE AK STREET ESTER, IN47394		(X5)
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
K0027 SS=E	Safety Code Special 04/27/11. The facility was with the aforeme requirements as of following Door openings in a 20-minute fire present 13/4-inch thick Non-rated protection 48 inches from the permitted. Horizon with 7.2.1.14. Door automatic closing 19.2.2.2.6. Swing to swing with egrenot required. 19 Based on observation facility failed to a smoke barrier do movement of sminutes. LSC 19 smoke barriers sland closing to smoke barriers sland closing minutes. LSC 19 smoke barriers sland closing the minimum proper operation inch. This defici	smoke barriers have at least otection rating or are at a solid bonded wood core. We plates that do not exceed to bottom of the door are not sliding doors comply ors are self-closing or in accordance with ing doors are not required as and positive latching is 1.3.7.5, 19.3.7.6, 19.3.7.7 action and interview, the ensure 1 of 6 sets of ors would restrict the toke for at least 20 0.3.7.6 requires doors in mall comply with Section quires doors in smoke as the opening leaving and clearance necessary for which is defined as 1/8 ent practice could affect reside on the 300 Hall.	K0	027	Please accepti tihis plan of correct as our credible allegation of compliance witih all regulatiory requirements Corrective action ftor aftectied resident! Itt is the intent of this ftacility ensure swinging doors are arrange so thatt each door shall be selftelosing and lattch. The 300 wir sett oft doors were repaired on Ap 25, 2011 tto close and lattch as required. Identification oft other residents.	tto d ng ril	05/11/2011

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Event ID:

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If continuation sheet

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED	
		155231	B. WING		04/25/2011	
NAME OF D	PROVIDER OR SUPPLIER		STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER		701 S C	AK STREET		
	PH NURSING HON			ESTER, IN47394		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	,	CY MUST BE PERCEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	TAG		DATE	
		ation on 04/25/11 at		risk;		
	10:45 a.m. with t			All setts oft ftre doors have been ttestted tto ensure tthatt each doo	or.	
	supervisor, the 30	00 Hall set of smoke		closes and lattches as required	,	
	barrier doors nex	t to the therapy room had		closes and latteries as required		
	• •	here the south door in the		Measures tto ensure tthis deftcien	itt	
		e floor on two separate		practtce does nott recur		
	•	the smoke barrier doors.		Mainttenance sttaft has been		
	This was verified	l by the maintenance		re-educatted tto ftederal regulatto		
	supervisor at the	time of observation.		K27. All ftre doors will be placed of a preventive mainttenance progra	l	
				ensuring all ftre doors close and	""	
	3.1-19(b)			lattch as required (see ftorm		
				Attachmentt A		
				,		
				Monittoring oft correcttve actton		
				All ftre doors will be placed on a		
				preventtve mainttenance program		
				ensuring all ftre doors close and		
				lattch as required(see ftorm		
				Attachmentt A. The mainttenance supervisor or his designee will		
				review each smoke barrier door		
				using ftorm Attachmentt A as part	t oft	
				Randolph's Qualitty Assurance		
				Program, ensuring tthe LSC		
				requirementt tthatt each door clos	ses	
				and lattches as required		
	F					
K0046		g of at least 1½ hour ed in accordance with 7.9.				
SS=E	19.2.9.1.	a in accordance with 7.9.				
		review and interview, the	K0046	K046	05/11/2011	
		ensure 1 of 1 battery		Please accepti tihis plan of correc		
	_	s tested at 30 day		as our credible allegation of		
		ually for a 90 minute		compliance witih all regulatiory		
		-		requirementis		
		re the light would provide		Correcttve actton ftor aftectted		
	lighting during p	eriods of power outages		<u>resident</u> t		

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
		IDENTIFICATION NUMBER:		LDING	01	COMPLETED
		155231	B. WIN	IG		04/25/2011
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE	
					DAK STREET	
RANDOI	PH NURSING HO	ME		WINCH	ESTER, IN47394	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	1 ^ -	sident using the main			Itt Is tthe inttentt oft tthis ftacilitty	
	dining room. LS	SC 19.2.9.1 requires			provide emergency lighttng oft att	
	emergency light	ing shall be provided in			leastt1 ½ hr duratton. The battery	
	accordance with	Section 7.9. Section			back up lightt locatted in tthe Main Dining Room has been removed.	n
	7.9.3 requires a	functional test shall be			Lighting in the Main Dining room	
	1 1	ery required emergency			had been added tto tthe generatto	or
		at 30-day intervals for not			battery back up lightt is nott need	
	1 0 0 1	onds. Equipment shall be			, , , , , , , , , , , , , , , , , , , ,	
		for the duration of the			Identtftcatton oft otther residentt	<u>s</u> att
					<u>risk;</u>	
		ords of visual inspections			Itt Is tthe inttentt oft tthis ftacilitty	tto
	and tests shall be kept by the owner for inspection by the authority having				provide emergency lighttng oft att	
					leastt1 ½ hr duratton. The battery	
	jurisdiction. Thi	is deficient practice could			back up lightt locatted in tthe Mai	n
	affect any reside	ents who use the main			Dining Room has been removed.	
	dining room.				Lighting in the Main Dining room	
					had been added tto tthe generatto battery back up lightt is nott need	
	Findings include	e:			battery back up lightt is nott need	Eu
					Measures tto ensure tthis deftcien	tt
	Based on an inte	erview on 04/25/11 at 9:40			practtce does nott recur	
	a.m. with the ma	intenance supervisor, the			Itt Is tthe inttentt oft tthis ftacilitty	tto
		pattery backup light			provide emergency lighttng oft att	
	I -	ain dining room. Based			leastt1 ½ hr duratton. The battery	
	on a review of the	•			back up lightt locatted in tthe Mai	n
		g Book and the Fire Drill			Dining Room has been removed.	
		~			Lighttng in tthe Main Dining room had been added tto tthe generatto	nr.
	1 -	was no evidence the			battery back up lightt is nott need	
		backup light was tested at			Sattery Suck up lighte is not lieed	
	1 .	als for 30 seconds, or			Monittoring oft corrective action	
		nety minute duration.			Itt Is tthe inttentt oft tthis ftacilitty	tto
		d by the maintenance			provide emergency lighttng oft att	
	supervisor at the	time of record review.			leastt1 ½ hr duratton. The battery	, [
					back up lightt locatted in tthe Mai	n
	3.1-19(b)				Dining Room has been removed.	
					Lighting in the Main Dining room	
					had been added tto tthe generatto	or
	!					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155231	(X2) M A. BUII B. WIN	LDING	NSTRUCTION 01	(X3) DATE S COMPL 04/25/2	ETED
NAME OF PROVIDER OR SUPPLIER RANDOLPH NURSING HOME			701 S C	ADDRESS, CITY, STATE, ZIP CODE DAK STREET ESTER, IN47394			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
K0047 SS=E	accordance with sillumination also so lighting system. Based on observation facility failed to dilluminated exit approvided with confus deficient provided with the residents who residents who residents who residents who residents with the therapy room. Based on observations include the supervisor, the 3d directional sign afrom the therapy illuminated. Baset the maintenance with supervisor with the resident provided with confus definitions and the supervisor with	and directional signs was ntinuous illumination. actice could affect 14 side on the 300 Hall near ation on 04/25/11 at the maintenance 00 Hall exit and above the exit door across room was not ed on an interview with supervisor on 04/25/11 at exit and directional sign	K	0047	K047 Please accepti tihis plan of correct as our credible allegation of compliance witih all regulatiory requirementis Corrective action ftor aftectied residentt Itt is the intent off this facility ensure all exitt and directtonal signare displayed witth continuous illumination. On April 25, 2011, ttl light bulb tto tithe exitt sign location tithe 300hall was replaced, the exisign proved tto be in working order providing illumination. Identification off of other residentistisk; All setts off exitt and directional signate were reviewed and proved tto be in working order. Measures to ensure tithis deficient practice does not recur Maintitenance staft has been re-educated tto ftederal regulation K47. All exitt and directional signs will be placed on a preventive maintitenance program ensuring exand directional signs have continuous illumination Monitoring off corrective action All exitt and directional signs will be existed to directional signs will exist and directional exist and d	tion tto ns he ed on tt r att n	05/11/2011

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155231	(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 04/25/2011		
NAME OF PROVIDER OR SUPPLIER RANDOLPH NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 701 S OAK STREET WINCHESTER, IN47394				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
K0050 SS=F	Fire drills are held varying conditions shift. The staff is t is aware that drills routine. Responsi conducting drills is competent person exercise leadershi conducted betwee announcement manudible alarms. Based on record facility failed to drills on each shi during the past y	at unexpected times under, at least quarterly on each familiar with procedures and are part of established bility for planning and assigned only to s who are qualified to p. Where drills are in 9 PM and 6 AM a coded ay be used instead of 19.7.1.2 review and interview, the conduct quarterly fire ft for 3 of 4 quarters ear to protect 74 of 74 deficient practice affects at least to protect at least to protect affects at least to protect affects at least to protect affects are facility.	K0050	placed on a preventive maintent program ensuring all exitt and directtonal signs have continuous illumination (see ftorm attachmed). The mainttenance supervisor his designee will review each exit and directtonal signs using (see fact Attachment B) as part of Rando Quality Assurance Program ensurance the LSC requirement that each and directtonal signs have continuous illumination. K50 Corrective action for after resident: It is the intent of the facility to hold fire drills at unexpected times under var conditions at least quarterly each shift. A Fire Drill was conducted on April 13, 2011 shift and May 10, 2011/third Quarter II for the year 2011. Identification of other	fected on the principle of the principle		
	book with the ma 04/25/11 at 9:00 of a fire drill con	w of the Fire Drill Log aintenance supervisor on a.m., there was no record ducted for the third shift, e year 2011; second or		residents at risk; Maintenan staff has been re-educated federal regulation K50. A F Drill was conducted on Apri 2011/first shift and May 10, 2011/third shift, Quarter II f year 2011. Measures to ens	to ire 13, or the		

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Event ID:

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If continuation sheet

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l l		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED	
		155231	B. WING		04/25/2011	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE		
		_	I	OAK STREET		
RANDOL	PH NURSING HON	∕IE	WINCE	HESTER, IN47394		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
		third quarter of the year		this deficient practice does n recur; Maintenance staff has		
	· · · · · · · · · · · · · · · · · · ·	st shift, second quarter of		been re-educated to federal		
	_	sased on an interview		regulation K50. A Fire Drill v	vas	
	with the mainten	ance supervisor on		conducted on April 13, 2011/	I	
	04/25/11 at 9:25	a.m., and after a fifteen		shift and May 10, 2011/third	shift,	
	minute review of	Tthe Fire Drill Log book,		Quarter II for the year 2011. Monitoring of corrective		
	the maintenance	supervisor indicated		action; Maintenance staff ha		
	there was no other	er documentation		been re-educated to federal		
	available for revi	ew to verify a third shift		regulation K50. A Fire Drill v		
	fire drill for the f	irst quarter of 2011, a		conducted on April 13, 2011/		
	second and third	shift fire drill for the		shift and May 10, 2011/third Quarter II for the year 2011.	shift,	
	third quarter of 2	010, and a first shift fire		Form (Attachment C) has be	een	
	_	nd quarter of 2010.		initiated to assist in conducting	I	
		1		fire drills at unexpected times	s,	
	3.1-19(b)			under varying conditions, at	least	
	3.1 17(0)			quarterly each shift. Form	nort	
				(Attachment C) will become of Randolph's Quality Assura	· I	
				Program, ensuring the LSC		
				requirement of conducting fir	·e	
				drills at unexpected times, ur	nder	
				varying conditions, at least		
K0076	Medical das stora	ge and administration areas		quarterly each shift.		
SS=E		ccordance with NFPA 99,				
00-L	Standards for Hea					
		e locations of greater than				
	separation.	closed by a one-hour				
	separation.					
	(b) Locations for s	upply systems of greater				
	·	re vented to the outside.				
	NFPA 99 4.3.1.1.2		170076		05/11/0011	
		ation and interview, the	K0076	K076	05/11/2011	
	_	ensure a minimum		Correcttve actton ftor aftectted residentt		
		st five feet separated		Itt is the intentt oft this ftacility	tto	
	combustible mate	erials from oxygen		mainttain a minimum disttance of		
				1		

000136

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 01 A. BUILDING 155231 04/25/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 701 S OAK STREET RANDOLPH NURSING HOME WINCHESTER, IN47394 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE bettween liquid oxygen and containers in 1 of 1 oxygen storage areas. combusttble matterial All NFPA 99, 8-3.1.11.2(c) requires oxidizing combusttble matterial has been gases such as oxygen shall be separated removed ftrom tthe 00 hall oxygen from combustibles by a minimum sttorage room distance of five feet if the required storage location is protected by an automatic Identtftcatton oft otther residentts att sprinkler system. This deficient practice risk; could affect 14 resident who reside on the All combusttble matterial has been removed ftrom tthe 300 hall oxygen 300 Hall near the oxygen storage room. sttorage room There is no otther oxygen sttorage room in tthe ftacilitty Findings include: Measures tto ensure tthis deftcientt Based on observation on 04/25/11 at practtce does nott recur All combusttble matterial has been 11:15 a.m. with the maintenance removed ftrom tthe 00 hall oxygen supervisor, the 300 Hall oxygen storage sttorage room There is no otther room had three full liquid oxygen oxygen sttorage room in tthe ftacilitty containers stored within one foot of eight Mainttenance and Housekeeping shelves of combustible plastic oxygen sttaft will be reeducatted tto Lifte supplies stored in cardboard boxes. This Saftetty Code **K**6. Form (Attachmentt D) will be incorporatted intto tthe was verified by the maintenance Housekeeping Departtmentt daily supervisor at the time of observation. schedule tto ensure a minimum disttance of ft bettween liquid 3.1-19(b)oxygen and combusttble matterial is mainttained Form (Attachmentt D) will become partt oft Randolph's Qualitty Assurance Program ensuring tthe LSC requirementt oft a minimum oft 5t bettween liquid oxygen and combusttble matterial is mainttained Monittoring oft corrective actton All combusttble matterial has been removed ftrom tthe 00 hall oxygen sttorage room There is no otther oxygen sttorage room in tthe ftacilitty

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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l	T OF DEFICIENCIES DF CORRECTION	IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155231	A. BUILDING B. WING	01	COMPLETED 04/25/2011
	ROVIDER OR SUPPLIER		701 S C	ADDRESS, CITY, STATE, ZIP CODE DAK STREET JESTER, IN47394	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				Form (Attachmentt D) will be incorporatted intto the Houseke Departtmentt daily schedule tto a minimum disttance of the bettwelliquid oxygen and combusttble matterial is mainttained Form (Attachmentt D) will become part Randolph's Qualitty Assurance Program, ensuring the LSC requirementt oft a minimum of the bettween liquid oxygen and combusttble matterial is maintta	ensure een t oft